Changes in the Administration of Psychotherapy During a Collective Upset

*Seymour Parker**

Studies of the therapeutic implications of the social environment of the mental hospital indicate that it is fruitful to view the behavior of patients as a function of the entire social context in which it is embedded. A deeper insight into both individual and social problems can often be obtained if the interpersonal and group organizational dimensions are considered along with the intrapsychic conceptualizations.(1) Given this point of view, it is important to view the behavior of staff members, toward one another and in relation to patients, in the same context. In the classical psychotherapeutic (two-person) situation this problem has been dealt with by focusing on counter-transference phenomena. Although such phenomena exist in all therapeutic situations, they do not provide us with an adequate frame of reference with which to examine staff-patient interaction in the complex role system and administrative organization of the mental hospital. Robert A. Cohen, in discussing the relation between staff tensions and the psychotherapeutic process, suggests that "the social situation may affect psychotherapeutic operations when patient and therapist are part of the same group. In this circumstance, problems which in the usual office situation would be contained within the patient-therapist relationship may now find expression in the patient-staff, staff-staff, and the therapist-staff relationships."(2) This conclusion is also supported by the findings of Stanton and Schwartz in their study of the mental hospital.(7) Changes were noted in symptom behavior in patients as a result of a disagreement between two staff members about how a particular case should be handled. These studies indicate the mutual interaction of patient and staff behavior, and point to the potential value of viewing the behavior of both as a mode of participation in the existing social processes within the institution.

* Seymour Parker, Ph.D., is Cultural Anthropologist, Dept. of Psychiatry, Jefferson Medical College of Philadelphia.

The research on which this paper is based was made possible by a grant from the Nuffield Foundation. It was carried out at the Belmont Hospital Social Rehabilitation Unit (England) under the direction of Dr. Maxwell Jones. Thanks are due to Dr. Robert Rapoport for his critical reading and comments. This paper was presented at the Annual Meeting of the Society for Applied Anthropology, April, 1958, in Syracuse, New York.

The investigation of the patterns of mutual interaction of staff and patient behavior becomes particularly pertinent in institutions attempting to utilize the social environment of the hospital as a therapeutic agent.(3, 4, 8) In such treatment setting both patients and staff members are active in joint decision-making on matters concerning therapy, social problems among patients, and hospital administration. Thus, the doctor-patient relationship is not confined to the structured private office situation, but pervades many areas of social life within the institution. Furthermore, the relationship is no longer confined to activities defined as psychotherapy as the term is commonly used. In the "therapeutic community" approach little distinction is made between treatment and administration. Most activities are considered to have therapeutic relevance. In this type of treatment setting, not only patients, but also other staff members (at various levels) interact with the therapist in a wide variety of situations. The broad and relatively unstructured involvement of the therapist with other staff personnel and patients raises a number of interesting questions. To what extent can the therapist maintain a permissive role (*vis à vis* the patient) when he is involved in group administrative decisions and responsibilities? Is conflict engendered by the fact that the participants in these decisions have different role responsibilities within the institution and in relation to the society outside? How are the transference and countertransference relationships affected by this joint social involvement of the patient and therapist?

In most mental institutions individual attempts are made to confine the contagion of potential strains in any part of the social organization by the mechanisms of unilateral decision-making according to formal role definition and a hierarchical chain of command. In the therapeutic community a conscious attempt is made to flatten the authority hierarchy and to reduce the specificity of role definitions as applied to the decision-making process. These innovations flow from the rationale underlying the milieu therapy approach.(4, 5) Although this is calculated to yield therapeutic benefits, there are indications that this type of social arrangement has a "recurring tendency for social disorganization and intrapersonal and interpersonal tensions to be generated in the system. These recurring ten-

dencies and their resolutions set up a pattern of oscillations in social organization." (9) Insofar as this observation is valid, it behooves us to study a concrete instance of disorganization in such a therapeutic setting, in order to understand more about the mutual influence of the various parts of the system and the therapeutic relevance of some of the adjustive mechanisms called into play to cope with the disturbed situation.

In this paper I shall try to show how the behavior of the staff in the Belmont Hospital Social Rehabilitation Unit (England) changed during a period of social disorganization in the institution.(4) Some of these changes consisted of alterations in the relationship among staff members themselves, which affected therapy indirectly. Other changes were more direct, comprising actual decisions on policy and practice with reference to treatment. As the study progressed, it became clear that the nature of the staff's behavior could be understood best when viewed as a part of the ongoing social processes in the Social Rehabilitation Unit.

The Community

In a previous paper(6) we discussed the development of the collective disturbance in the Social Rehabilitation Unit and detailed some of the changes that took place in both social organization and symptom formation among the patients. Before discussing the reactions of the staff members it would be well to describe briefly the hospital and to mention something about the background of the crisis situation. The Belmont Hospital Social Rehabilitation Unit functions as a therapeutic community for the treatment of patients diagnosed as psychopathic personalities and related character disorders. Psychotics and mental defectives are not admitted for treatment. Admission to the hospital is on a voluntary basis and patients are free to leave whenever they so desire. The Rehabilitation Unit operates as a semi-autonomous section of a larger neuroses treatment center, to which it is administratively attached. As mentioned previously, the prevailing social climate at the Rehabilitation Unit is characterized by a flattening of the authority hierarchy and participation of community members (both staff and patients) in many administrative and therapeutic decisions. As far as possible, a permissive atmosphere is maintained, in spite of the tendency toward anti-social acting-out on the part of the patients.

The Crisis

Just previous to the onset of the collective disturbance referred to, strong external pressures were brought to bear on the staff. These pressures consisted mainly of objections to the permissive methods of treating anti-social behavior in an open hospital. Although these feelings about the Unit's treatment methods were always latent, they erupted at this time because of some anti-social behavior on the part of a few patients. It was alleged by some of the external critics that patients of this type might be too disturbing to the local community. Questions were raised about the possibility of moving the Rehabilitation Unit "out into the country." Members of the staff were experiencing considerable job insecurity and some were worried about the possibility of having to move away from their homes to another area.

At the height of this critical period a few patients had to be discharged for extreme anti-social behavior. Two of these individuals occupied positions of leadership in their wards. During the next two months hostile attitudes toward the staff mounted, violations of hospital rules became more frequent, communications between the patients and the staff decreased markedly, and early self-discharges became more frequent. As the problem of social control and discipline in the Rehabilitation Unit increased, the strains in the relationship between the staff and outside authorities became more acute.

This was, briefly, the picture of the situation that confronted the staff personnel of the Unit during the period with which we are concerned. In the course of their attempts to work through the problems associated with the disturbance to better therapeutic advantage, various solutions were attempted. These attempts, in turn, had further effects on the patients and on intra-staff relationships. In the remainder of this paper I shall list and discuss some of the major staff reactions to the institutional crisis.[1]

A. *The Administration of Discharges*

In this general area there were two major changes that emerged during the period of crisis. As an immediate reaction to pressure from outside authorities and increased acting-out among the patients, staff members seemed more likely than previously promptly to discharge patients who acted-out in a way that might further endanger the Unit's relations with outside authorities. Thus, patients who destroyed property outside of the hospital or misbehaved in the nearby town were either discharged immediately or told that they would have to leave if their offenses were repeated. The number of disciplinary discharges rose during this period, and the manner in which they were effected changed considerably. Ideally, when a patient in the Unit acts-out, this behavior is discussed in the next community meeting or in his doctor's group. The incident is considered to be part of his illness and an attempt is made to deal with it in a permissive and therapeutic fashion. If his doctor felt that he should be discharged, it was usually discussed with other patients, and their opinions were carefully weighed. During the crisis period, the staff's tolerance threshold seemed lowered, and they tended to discharge patients summarily if their behavior constituted a serious disciplinary problem. It was of the utmost importance, while external pressures were impinging on the Unit, that such problems be dealt with speedily and effectively. In most of the discharges of this type, the decision was made with but little discussion and consideration of patient opinion. Patients tended, on their part, to be increasingly prone to view staff-initiated discharges as punitive and authoritarian. Thus began a widening circle of more hostility, anxiety, and acting-out by the patients, mounting anxiety and summary discharges by the staff, and so on.

Staff members began to feel that the hostility being expressed by patients had passed the tolerance level of the community and was becoming therapeutically harmful.

1. During the crisis period I attended almost all of the staff meetings and most of the community meetings in the Rehabilitation Unit. I also participated regularly in the daily group therapy session and in the weekly ward meetings. Individual interviews were carried out with most of the members of the permanent staff.

Pathological symptoms and social problems were increasing, and a larger than usual number of newly arrived patients were leaving the Unit after a short stay. Some of the doctors attempted to compensate for this by altering their discharge policies. This attempt consisted of going to an extreme in some cases and holding on to patients whom they ordinarily would have discharged as being unsuitable for further treatment. They were reluctant to discharge these individuals for fear of arousing additional antagonism and damaging further the relationship with their patients.

During a staff meeting one of the doctors spoke about his patient G. C. who had become "destructively anti-staff and had been out drinking regularly and caused considerable disturbances in the ward." He felt that if this had happened a few months previously he would have discussed it with the group and asked him to leave the Unit. "However," he said, "because of the mass paranoia that exists among the patients I don't dare to discharge him now."

The following week, at another staff meeting, a senior staff psychiatrist made the following statement: "I'm impressed at the moment with how the staff is tending to hold on to patients that we all feel cannot be helped here. I think it makes all treatment more difficult when we become soft-hearted and try to hold on to patients—it is a good thing for the Unit to prune once in a while." He went to to say that he felt they should start pruning now. Most of the permanent members of the staff disagreed with this recommendation very strongly. They agreed that "pruning" was occasionally desirable as a general policy but would be extremely unwise at a time when the staff were viewed as punitive disciplinarians. One of the doctors spoke about the dilemma that this problem presented to him. Since the time that one of his patients was discharged summarily, his group therapy sessions were not progressing satisfactorily. On the one hand, he felt that if he discharged certain patients in his group (who he felt could make no further progress) and get "some new blood," the groups might improve. However, he, too, was reluctant to do this for fear of strengthening the existing anti-staff stereotype.

B. *Administration of the Admission Policy*

During the first part of the collective disturbance the main pressure on the admission policy stemmed from events outside of the Unit. The mounting outside criticism concerning the "lack of discipline" among the patients had a decided effect on the type of patients who were admitted by the Unit. After discussing the current situation, the staff decided that, for the time being at least, patients who had histories of exceptionally severe aggressive anti-social behavior should not be admitted. It was felt that taking in such potential "actors-out" would be equivalent to "asking for trouble." Thus there was a change in the admission policy involving a raising of the Unit's hitherto low barriers against accepting such cases in an open hospital. This was done on a quite conscious and overt basis. It should be noted that the treatment ideology and methods were specifically geared to treating just this kind of patient, who now was not admitted.

Selecting for non-violent types of patient was not immediately successful as a way of reducing disruptive behavior. Disorganization mounted in response to forces internal to the Unit and anti-social behavior increased. This had the effect of reinforcing the changed admission policy. At a staff meeting, where decisions were being made about the suitability of applicants for admission, one of the senior staff members expressed the view that he did not want to risk taking in patients who might "cause trouble." Furthermore, he was anxious that the doctors discharge patients who were trouble-makers. This pressure was resented by some of the other staff psychiatrists. They complained that the democratic process by which admission decisions had been made in the past was being by-passed. In addition, they felt rather discouraged and unhappy at having to forego treating patients who, they felt, were uniquely helped by community treatment methods.

During a staff meeting toward the end of January, a discussion took place about the case of a former patient, with strong anti-social tendencies, who was applying for readmission. Accompanying the application for admission was a request from one of the social welfare agencies that this boy be given another chance to have treatment. When he was discharged a few weeks previously his doctor told him that he would consider readmitting him when he (the patient) felt able to accept treatment. The doctor thought that this patient could, if properly motivated, benefit considerably from treatment in the Unit under ordinary circumstances. The Director of the Unit said that he would have no objection if the patient were readmitted. However, the patient's own doctor now refused to have him back and made a statement that reflected the sentiments of a good part of the staff. He said that, given the existing pressures from the outside, plus the anxieties of the staff, the usual Unit conditions which he considered favorable for treating the aggressive psychopathic type of patient did not exist. Furthermore, he felt that it would be psychologically dangerous to subject this boy to the possibility of being discharged again. Considering this risk, he decided against accepting him for treatment at this time.

C. *Individualization of the Treatment Methods*

Before describing the changes that took place in this area let us first briefly discuss treatment in the Unit as it ordinarily occurs. Although the individual patient is assigned, technically, to one doctor who has formal responsibility for him, the doctor may or may not be the most important person in the patient's treatment. Whether or not he is the most important treatment influence, he has formal responsibility for treatment, and in discharging this responsibility according to Unit ideals, he shares treatment functions with other staff members and patients in the community. Other staff members (i.e., Social Therapists,[2] Psychiatrists, Social Workers, Sisters, Workshop

2. The position of Social Therapist has no exact parallel in other mental institutions. For the most part, the Social Therapists are girls between the ages of twenty and thirty years, often with training in the social sciences. They are chosen for their personal qualities and work in the Unit for six months to a year. The majority have no medical background and usually have little more than lay knowledge of psychiatry. They participate with patients in the various activities of the day, and also perform some relatively simple nursing duties. Their lack of professional training and detachment from the orthodox nursing hierarchy was thought to enable them to relate more spontaneously to both patients and senior staff members. These relatively untrained girls are, however, guided by the more senior staff members through a daily tutorial system. The Social Therapists constitute an important liaison between the permanent staff and the patients.

Instructors, etc.) interact with and "treat" the patient in situations where the officially responsible doctor is not present. They take an active part in group therapy sessions, ward meetings, community meetings, and staff meetings. In this way the patient's social behavior in many situations is made known to a widespread sector of the community members, who then contribute to the common fund of knowledge essential for treatment. Relatively free communication and collective participation in treatment are central to the Unit's psychotherapeutic methods and usually prevail in practice, as well as theory.

During the crisis period there occurred a considerable constriction of this collective responsibility, and doctors were reluctant to "interfere" in the treatment of their colleagues' patients. In addition, other permanent staff members and the Social Therapists sometimes felt it "wiser" not to take an active role in treatment. This phenomenon was undoubtedly related to the anxieties and friction in the staff that began to mount during this period. At one (relatively silent) staff meeting in the third week in January, the Unit's Social Worker suddenly said that she was reluctant to bring up problems concerning some of the patients because she feared that her remarks would be interpreted by other staff members as being overly critical and punitive. One senior doctor agreed that this was a prevalent feeling among staff members and that he too was "afraid to open my mouth about patients other than my own because I would get jumped on." The Social Worker went on to draw a parallel between what was happening to the staff and to the patients. In both groups, she said, if a person's behavior was discussed, it would be regarded as punitive and arouse feelings of anxiety and anger. She felt that "everyone is so hypercritical of each other." Some doctors complained during this period that intra-staff communications were very poor. Previously they had some knowledge of patients other than their own—now this knowledge was minimal.

The staff meetings were punctuated with long periods of silence and there was little exchange of information about patients. Two of the doctors had noticeably withdrawn from active participation in these meetings and one of them, when questioned about it, said that he felt the staff meetings were useless and should be eliminated. In spite of the fact that he had strong feelings about the matter, he was reluctant to discuss the point further. Although this suggestion was not followed, many people held similar sentiments. In a sense, more individual therapy began to be carried out in the community setting. Each doctor addressed himself, within the large meetings, to the problems presented by his own patients, with but little discussion by other staff members.

D. *Attempts to Create New Channels of Communication*

In the discussion above we pointed out that communication between members of the staff was minimal during the period under consideration. The staff meetings were attended, but not utilized efficiently for exchanging significant information. Doctors, who were not present at a family group meeting[3] or a workshop meeting had little opportunity here to learn about important aspects of their patients' behavior. It was also evident that communication between the patients and the staff was drastically reduced. Thus a situation arose where most of the ordinary channels of communication between the patients and the staff, and among members of each group, were either closed or seriously impaired. Related to this phenomenon was the growing feeling of dissatisfaction by all concerned with the effectiveness of the Unit's treatment under these circumstances. The inability to utilize the old channels of communication, plus the realization that treatment was being hindered by this, gave rise to staff pressures to seek new ways of communicating. The following are a few of the changes brought about during the crisis, that affected the patterns of communication:

1. Two of the four doctors in the Unit began to see their patients more often in private interviews. Although private interviews were always a part of treatment in the Unit, most of the doctors felt that in the setting of the therapeutic community they should be kept to a minimum. The tendency had been to discourage patients from seeking individual attention. Private interviews were, on the whole, seen as fostering dependency relationships and reducing communications with the other patients and staff members of the community. At this time, however, the doctors concerned felt that the group situation was fraught with so many tensions and anxieties that patients might communicate better in private.

2. Up to the beginning of January only one of the four psychiatrists participated with the patients in their workshop activities. During the crisis period two additional doctors joined a work group and participated in the regular work duties and meetings of that group. One of the doctors joined the "home" group where she helped to clean and tidy the wards. The other joined the painting group. Both felt that by doing this they "could get closer to the patients" and speak to them in a "less tense atmosphere." During the same period two other Unit professional staff members also joined a workshop.

3. Toward the end of January the long silences in the Staff meetings became increasingly anxiety-laden. Some of the members of the senior staff became openly critical of the Social Therapists for not speaking more at these meetings and not passing on information about the patients. The pressures on the Social Therapists to communicate mounted to such a point that some of the girls became upset and special meetings were held to find out "why the therapists did not communicate more." The Social Therapists, having more informal interaction with the patients than any other members of the staff, were in a key position in the communication system. Actually, the efforts to increase their communication were fairly successful. They began to talk more at the various staff meetings and requested additional formal psychiatric instruction from the staff.

4. As the crisis heightened, more staff members became actively dissatisfied with the amount of information they were getting about the patients, and with the understanding that they had of the dynamics of the cases. In general there was more abstract discussion in staff meetings about the nature of the treatment processes in a therapeutic community and the

3. Special group therapy sessions to which close relatives of some of the patients were invited.

ways in which it differed from individual psychotherapy. Some of the senior doctors felt that the staff should make determined efforts to understand more about the psychodynamics and theoretical implications of the community experience for each case. When spontaneous discussions of this order were not forthcoming at the staff meetings, attempts were made to assign specific research topics to some of the junior psychiatrists. While the orientation of the leadership of the Social Rehabilitation Unit generally places high value on analytical self-examination, discussions, and research, there were special pressures pushing in this direction during the crisis period.

5. Though the Unit developed within a larger psychiatric hospital, its differences of treatment methods and interests have contributed to a considerable feeling of separateness from the remainder of the hospital. The reduction of the interaction between Unit and hospital staff had the positive function of bringing about a feeling of distinctiveness and cohesiveness within the Unit. However, during the period of crisis there were spontaneous attempts by the Unit's staff to reverse this trend and interact more frequently with the hospital staff personnel. In this period of anxiety the staff manifested more concern about their relationships with professional colleagues outside of the Unit. Special efforts were made by some of the Unit's staff to attend Hospital Case Conferences and to participate more frequently in formal teas and lunches with other hospital staff members.

E. *The Use of Latent Staff Authority*

As mentioned above, the staff felt that it was not always possible during this period to approximate in practice their ideals of permissiveness and democracy. At times, because of the seriousness of the internal organizational problems, combined with external pressures, they had to act in a way that was at variance with their stated ideology. This was noticed in the way some of the discharges were handled. From the vantage point of the staff, this change in procedure was temporarily necessitated by the administrative situation. In the eyes of the patients, however, these acts were seen as expressing the "hypocrisy" of the staff and were viewed as punitive.

As the crisis situation heightened, the amount of time devoted by the staff to the discussion of internal disciplinary problems (at the community meetings and ward meetings) increased. More and more of these discussions centered around the uncooperative and disruptive behavior of patients. There were a number of statements made by the staff to the effect that individuals who persistently acted-out would have to leave. On a few occasions the patients were told that their behavior was contributing to the external difficulties of the Unit.

The behavior of the staff during the crisis was discussed by sub-groups of staff and patients, and considerable differences in the perceptions of its motivation and therapeutic desirability were noted. There was a tendency for patients to regard the staff as punitive and vindictive. Among the staff members themselves, there were sharp differences of opinion. Some staff members felt that in view of the seriousness of the criticism from outside sources and the amount of current acting-out, it was necessary (both administratively and therapeutically) to exert authoritative pressure on the patients so that they would be forced to face squarely the "reality situation." Others were equally convinced that in view of the degree of anxiety being exhibited by the patients, it was necessary to "soft-pedal" the reality situation. Those staff members holding the latter opinion maintained that the others were being over-anxious in the situation and were responding to their own "puritanical and authoritarian super-egos." On the other hand, those advocating the desirability of having the patients share the reality problems felt that the others were not carrying their share of the responsibilities and not sufficiently concerned with the fate of the Unit. Some staff members complained that they could not give effective treatment as long as they were viewed by the patients as "bad authority" figures. These differences led to a situation where some of the psychiatrists reduced their active participation in group meetings, while others became more active and authoritative in enforcing discipline in the community.

Conclusions

Some of the observations in this paper point quite definitely to the fact that staff behavior during the crisis was functionally related to the total situation in which therapy was being administered. Various institutional practices and treatment policies were altered, not only in response to a theory of treatment, but as a means of dealing effectively with the current administrative pressures. As a matter of fact, some of the criteria of what practices constituted, or did not constitute, good therapy were reinterpreted at this time. In some cases individuals who could no longer benefit from treatment were kept on in order to avoid accusations of "authoritarianism." Other patients, of the type usually treated to advantage in the Unit were not accepted for treatment. There were differences of opinion concerning the timing and the degree to which the patients should be confronted with the "reality picture" and at what point latent staff authority should be invoked.

Attempts to establish new channels of communication arose in response to the impairment of the existing channels. This problem affected communications not only between the patients and the staff, but also among staff members themselves. The increase of treatment in the private office situation cut down on joint participation of staff members in treatment problems. This trend was, to some extent, counterbalanced by attempts on the part of staff members to intensify their discussions of abstract problems of milieu therapy. The reduction of communication between patients and staff and the failure of communication in the existing groups gave rise to the decision of some psychiatrists to work with patients in the workshops. This certainly influenced both the amount and the nature of communication in the doctor-patient relationship. Whatever the ultimate therapeutic or untherapeutic effects of these changes, the point to be noted is that the changes of opinion and practices that arose among staff members impinged on the patients and influenced their treatment. The way the latter perceived events affected them at both the group organizational and individual levels of functioning.(6)

Some of the observations presented here have implications for the use of permissiveness in such a therapeutic milieu. A

permissive environment is created so that the patient will be encouraged to participate actively in the institutional setting. Among other things, this has the effect of reducing the usual strong feelings of dependency on the staff. On the other hand, the emphasis on permissiveness can boomerang and become therapeutically detrimental if the therapist finds it necessary at times (for either medical or administrative considerations) to depart from his usual and expected level of permissiveness. He is then perceived by the patient as a hypocrite and an authoritarian who is "finally showing his true colors." Thus one of the strengths of this type of treatment approach becomes, in times of crisis, a weakness. Very much the same applies to the practice of joint democratic decision-making. Perhaps this difficulty could be avoided somewhat if the staff made special efforts to temper the concepts of "equality" and "permissiveness" with the idea that the distribution of authority must be determined by the differential allocation of skills and responsibilities within the system.

In regard to the question of transference and countertransference problems, there is little doubt that the difficulties of understanding and evaluating these phenomena are compounded by the fact that the patient and therapist interact in such a wide variety of situations. This also makes the therapist a convenient target for the hostility that may arise from the patient's current interaction within the hospital. On the positive side of the ledger, however, is the fact that this kind of broad involvement of the patient and therapist allows the latter to observe firsthand the patient's interaction with different types of people in a variety of situations. The question of the relative advantages or disadvantages of this type of interaction cannot be answered with any degree of certainty.

Institutions like the Social Rehabilitation Unit, that work actively with milieu therapy, have brought into sharp focus the areas of convergence between administration and therapy. Likewise, this kind of treatment approach has made us more aware of the mental hospital as a social system in which both staff members and patients participate. We are now at the point of exploring further some of the therapeutic implications and possibilities of this social participation.

References

1. Caudill, William, Frederick Redlich, Helen Gilmore, and Eugene Brody, "Social Structure and Interaction Processes on a Psychiatric Ward," *Am. J. Orthopsychiat.,* 32: 314-334 (1952).
2. Cohen, Robert A.: "Some Relations between Staff Tensions and the Psychotherapeutic Process" in Milton Greenblatt, Daniel J. Levinson, and Richard H. Williams, *The Patient and the Mental Hospital,* The Free Press, Glencoe, Illinois, 1957.
3. Greenblatt, Milton, Richard H. York, and Esther L. Brown, *From Custodial to Therapeutic Patient Care in Mental Hospitals,* Russell Sage Foundation, New York, 1955.
4. Jones, Maxwell, *The Therapeutic Community: A New Treatment Method in Psychiatry,* Basic Books, New York, 1953.
5. Parker, Seymour, "Role theory and the treatment of the anti-social acting-out disorders," *Brit. J. Delinquency* 8: 285-300 (1957).
6. Parker, Seymour, "Disorganization on a Psychiatric Ward: The Natural History of a Crisis," *Psychiatry* (in press).
7. Stanton, Alfred H., and Morris Schwartz, *The Mental Hospital: A Study of Institutional Participation in Psychiatric Illness and Treatment,* Basic Books, New York, 1954.
8. von Mering, Otto, and Stanley H. King, *Remotivating the Mental Patient,* Russell Sage Foundation, New York, 1957.
9. Rapoport, Robert N., "Oscillations and Sociotherapy," *Human Relations* 9: 357-374 (1956).